

MATERNAL SUMMARY
Maternal Basic Demographics

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Beneficiary Name:

Medicaid Id:

Date of Birth:

Maternal Risk Identifier Completed Date:

EDC (Due Date):

Birth Outcome:

Infant Followed in MIHP: ☒ Yes ☐ No

Maternal Services Completed:

Prenatal Visits:

IBCLC Visits:

Enrolled in WIC: ☐ Yes ☐ No

Family Planning Method Identified: ☐ Yes ☐ No

Family Planning Method in Place: ☐ Yes ☐ No

Entered Prenatal Care:

Identify at Least 1 Support Person: ☐ Yes ☐ No

Breastfeeding Initiated:

Breastfeeding Duration:

Currently Breastfeeding:

Infant Birth Weight: lbs. oz.

Infant Gestation Age:

Tobacco Risk Identified: ☐ Yes ☐ No

Reduced Tobacco Use: ☐ Yes ☐ No

Quit Tobacco Use: ☐ Yes ☐ No

Depression Risk Identified: ☐ Yes ☐ No

Referral for Mental Health Services: ☐ Yes ☐ No

Followed Through with Referral: ☐ Yes ☐ No

Save

Save/Next

Clear

Cancel